Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DANIEL TUFT, MD
3100 TIMMONS LANE, STE 250
AUSTIN, TX 77027

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-3390-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. The requestor provided designated doctor services 3/18/11 by determining maximum medical improvement (MMI) and impairment (IR) then billed Texas Mutual $950.00 for this with one unit of code 99456-W5… Texas Mutual paid the requestor $650.00 for this MMI exam. (Attachment 1). The requestor submitted an amended bill to Texas Mutual on 4/12/10. This bill has a different billed amount for code 99456-W5 and the number of units was changed from 3 to 5. Texas Mutual reviewed this amended bill then reimbursed the requestor an additional two units at $150.00 for IR of the groin and $50.00 for the abdominal pain. (Attachment 2) No further payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 18, 2011	99456-W5-WP and 99456-MI	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated April 20, 2011
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.

   Explanation of benefits dated May 05, 2011
   - CAC-B22 – THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
   - 907 – ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE. NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.

   Explanation of benefits dated May 23, 2011
   - 193 – ORIIGNAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - B22 – THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 790 – THIS CHARGE WAS REIMBURSED AFTER RECONSIDERATION
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
   - 907 – ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE. NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.

   Explanation of benefits dated May 23, 2011
   - CAC-18 – DUPLICATE CLAIM/SERVICE.
   - 224 – DUPLICATE CHARGE.
   - DUPLICATE OF 10084814

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor original submitted a billing for the DD examination Maximum Medical Improvement/Impairment Rating (MMI/IR) services for 3 body areas/units in box 24G of the CMS-1500 for $950.00 and billed with CPT code 99456-W5-WP. This amount was paid prior to MFDR. After this payment, the requestor amended their billing and added 2 additional body areas/units for a total of $1250.00 for CPT code 99456-W5-WP. An additional line item was also billed CPT code 99456-MI representing multiple impairments for $50.00. The respondent re-audited the billing and allowed an additional $200.00 making the pre MFDR reimbursement $1,150.00. Review of the documentation supports that MMI was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. The cervical, groin pain, abdominal pain, and the left elbow, and hips are the five areas claimed as rated. The bilateral hips show range of motion but the hips (for fee guideline purposes) are part of the spine which is rated per DRE. Because per Texas Administrative Code §134.204(j)(4)(C)(i)(I), lumbar, cervical, thoracic and pelvis/hip are part of one body area, the spine. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) Category I method on the lumbar and the bilateral hips (spinal region) is $150.00. Documentation supports a Range of Motion (ROM) IR method on the left elbow (upper extremity) for a MAR of $300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a). The IR per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the two non musculoskeletal conditions of groin pain and abdominal pain is per 28 Texas Administrative Code §134.204 (j)(4)(D)(iv) and (v) and has a MAR of $150.00 x 2 = $300.00. Since there are only 4 areas rather than 5, the combined MAR for the MMI and the 4 units reimbursable for the IR areas is $1,100.00. The CPT code 99456-MI has already been reimbursed for $50.00.
2. The respondent has already reimbursed the MAR of $1,100 for the disputed CPT code 99456-W5-WP and $50.00 for CPT code 99456-MI. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 09, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.